EXHIBIT 6

FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.
***INSTRUCTIONS AND CODES ON THE REVERSE SIDE* - Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI): Ferrie Daniel
2. Home Telephone Number: 508-669-6349
3. Social Security Number*: 024-36-0166
4. Sex: ☑ M ☐ F
5. Home Address (No., Street, City, State & Zip Code): 1600 Pine Street Dighton, MA 02715
6. Marital Status: ☐ M ☐ S
7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy): 07/10/1998
9. Date of Birth (mm/dd/yyyy): 02/14/1947
10. Average Weekly Wage: $1709.62 ☑ Estimated ☐ Actual

EMPLOYER

11. Employer's Name: Kmart
12. Federal Tax I.D. Number: 380729500
13. Employer's Address (No., Street, City, State & Zip Code): 7A11state Road Boston, MA 02125
14. Employer's Telephone Number: 781-843-5400
15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR): Cambridge Integrated Services 866-639-7835
17. W.C. Policy Number: Kmart 177617-03MA
18. Self-Insured? ☑ Yes ☐ No
If Yes, Self-Insurer Number:
19. Business Type: ☐ Service ☐ Wholesale ☐ Mfg. ☑ Retail ☐ Other

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy): 12/17/2003
21. Was Employee Injured on Employer's Premises? ☑ Yes ☐ No
22. Location of Injury if not on Employer's Premises:
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy): 12/18/2003
24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy): 12/22/2003
25. If Employee has Died, Date of Death (mm/dd/yyyy):
26. Source of Injury (Chemicals, Machinery, etc.): Plastic bag
27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved: Slipped on a plastic bag a fell landing on his left side.
28. Person to Whom Injury was Reported (list position):
29. Date Reported (mm/dd/yyyy): 12/17/2003
30. Date Reported as work related (mm/dd/yyyy): 12/18/2003
31. Injury Code(s) a. 160 to body part; Body Part Code(s) a. 700; b. to body part; b.; c. to body part; c.
32. Witness(es) to Injury - Give Full Name(s), if none state as such: KMART00251
33. Has Employee Returned to Work? ☐ Yes ☑ No
34. Date Employee Returned to Work(mm/dd/yyyy):
35. Employee's Regular Occupation: Store manager
36. Has Employee Returned to Regular Occupation: ☐ Yes ☑ No
37. EMPLOYER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE): Kimberly Bouley
38. Title: Claims Adjuster
39. EMPLOYER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE): Kimberly Bouley
40. Date Prepared (mm/dd/yyyy): 01/06/2004

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 - Revised 8/2001 - Reproduce as needed.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.